

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 249 Drug Overdoses

SPONSOR(S): Rommel and others

TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Langston	McElroy
2) Criminal Justice Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Drug overdose is now the leading cause of injury-related death in the United States. In Florida, 3,228 people died of a drug overdose in 2015.

Currently, health care providers are not required by law to report to law enforcement when they treat or attend, or are requested to treat or attend a patient who may have overdosed on a controlled substance.

HB 249 creates s. 893.22, F.S., which requires health care providers to report controlled substances overdoses. The reporting requirement applies to physicians, nurses, paramedics, emergency medical technicians, health care workers, and employees of these professionals. It also applies to any employee of a hospital, sanatorium or other institution or provider. If any of these specified individual knowingly attends, treats, or is requested to attend or treat a person who has an overdose of a controlled substance as listed in s. 893.03, F.S., they are required to make a report to law enforcement within 24 hours or face criminal penalties.

The bill requires the report to be filed with the county sheriff or chief law enforcement officer of the county within 24 hours. However, the sheriff or chief law enforcement office may designate or partner with another agency, such as the medical examiner, to receive, store, and manage these reports, which must be maintained for five years.

Additionally, the law enforcement officer who receives these reports may share the general data, other than any data about criminal charges, with health care professionals and the county health department. Each county health department must then make semi-annual reports to the Statewide Drug Policy Advisory Council that summarizes the data it receives from law enforcement. The Council may use the reports to maximize the utilization of funding programs for substance abuse treatment services.

The bill will have a significant negative fiscal impact on the Department of Health.

The bill provides an effective date of October 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.¹ Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.² Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.³ Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.⁴

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.⁵ The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.⁶

Opioid Abuse

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.⁷ Drug overdose is now the leading cause of injury-related death in the United States.⁸ In 2015, Florida ranked fourth in the nation with 3,228 deaths from drug overdoses⁹, and at least one opioid caused 2,530 of those deaths.¹⁰ Statewide, in 2015, heroin caused 733 deaths, fentanyl caused 705, oxycodone caused 565, and hydrocodone caused 236; deaths caused by heroin and fentanyl increased more than 75% statewide when compared with 2014.¹¹

Drug overdose deaths doubled in Florida from 1999 to 2012.¹² Over the same time period, drug overdose deaths occurred at a rate 13.2 deaths per 100,000 persons.¹³ The crackdown on "pill mills" dispensing prescription opioid drugs, such as oxycodone and hydrocodone, reduced the rate of death

¹ WORLD HEALTH ORGANIZATION, *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 13, 2017).

² SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Substance Use Disorders*, available at:

<http://www.samhsa.gov/disorders/substance-use> (last visited March 13, 2017).

³ NATIONAL INSTITUTE ON DRUG ABUSE, *Drugs, Brains, and Behavior: The Science of Addiction*, available at:

<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction> (last visited March 1, 2017).

⁴ Id.

⁵ Supra, note 2.

⁶ Id.

⁷ WORLD HEALTH ORGANIZATION, *Information Sheet on Opioid Overdose*, November 2014.

http://www.who.int/substance_abuse/information-sheet/en/ (last visited March 13, 2107).

⁸ TRUST FOR AMERICA'S HEALTH, *The Facts Hurt: A State-by-State Injury Prevention Policy Report 2015*, available at:

<http://healthyamericans.org/reports/injuryprevention15/> (last visited March 11, 2017).

⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Drug Overdose Death Data*, available at:

<https://www.cdc.gov/drugoverdose/data/statedeaths.html> (last visited March 11, 2017).

¹⁰ FLORIDA DEPARTMENT OF LAW ENFORCEMENT, *Drugs Identified in Deceased Persons by Florida Medical Examiners-2015 Annual Report*, available at: <https://www.fdle.state.fl.us/cms/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2015-Annual-Drug-Report.aspx> (last visited on March 11, 2017).

¹¹ Id. at pg. 3.

¹² FLORIDA DEPARTMENT OF HEALTH, *Special Emphasis Report: Drug Poisoning (Overdose) Deaths, 1999-2012*, available at:

<http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/documents/CDC-Special-Emphasis-Drug-poisoning-overdose-1999-2012-B-Poston-FINAL.pdf> (last visited on March 11, 2017).

¹³ Id.

attributable to prescription drugs,¹⁴ but may have generated a shift to heroin use, contributing to the rise in heroin addiction.¹⁵

Emergency Response to Overdose

Opioid overdose can occur when an individual deliberately misuses a prescription opioid or an illicit drug such as heroin.¹⁶ It can also occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose, an error was made by the dispensing pharmacist, or the patient misunderstood the directions for use.¹⁷ Opioid overdose is life threatening and requires immediate emergency attention.¹⁸

To treat an opioid overdose, emergency personnel or a physician may administer an opioid antagonist such as Narcan or Naloxone. An opioid antagonist is a drug that blocks the effects of exogenously administered opioids. Opioid antagonists are used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.¹⁹ This occurs because opioid antagonists create a stronger bond with opioid receptors than opioids. This forces the opioids from the opioid receptors and allows the transmission of signals for respiration to resume.²⁰

From 2004 through 2009, emergency department visits nationally involving the nonmedical use of pharmaceuticals increased 98.4%, from 627,291 visits to 1,244,679 visits.²¹ In 2009, almost one million emergency room visits nationally involved illicit drugs, either alone or in combination with other drugs.²² From 2008 to 2011, about half of all emergency department visits nationally for both unintentional and self-inflicted drug poisoning involved drugs in the categories of analgesics²³, antipyretics²⁴, and antirheumatics²⁵ or sedatives, hypnotics, tranquilizers, and other psychotropic agents.²⁶

Opiates or related narcotics, including heroin and methadone, accounted for 14% of emergency department visits nationally for unintentional drug poisoning from 2008 to 2011.²⁷ In Florida, there were approximately 21,700 opioid-related emergency department visits in 2014.²⁸

¹⁴ *Supra*, note 10.

¹⁵ WORLD HEALTH ORGANIZATION. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 10, 2017).

¹⁶ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Opioid Overdose Prevention Toolkit*, Rev. 2016, available at, <http://store.samhsa.gov/shin/content/SMA16-4742/SMA16-4742.pdf> (last visited March 13, 2017).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ HARM REDUCTION COALITION, *Understanding Naloxone*, <http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/> (last visited 2/27/15).

²⁰ HARM REDUCTION COALITION, *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, Fall 2012. <http://harmreduction.org/our-work/overdose-prevention/> (last visited 2/27/15).

²¹ NATIONAL INSTITUTE ON DRUG ABUSE, *Drug-Related Hospital Emergency Room Visits*, available at: <https://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits> (last visited March 9, 2017).

²² *Id.*

²³ Analgesics are drugs that produce insensibility to pain.

²⁴ Antipyretics are drugs that reduce fever.

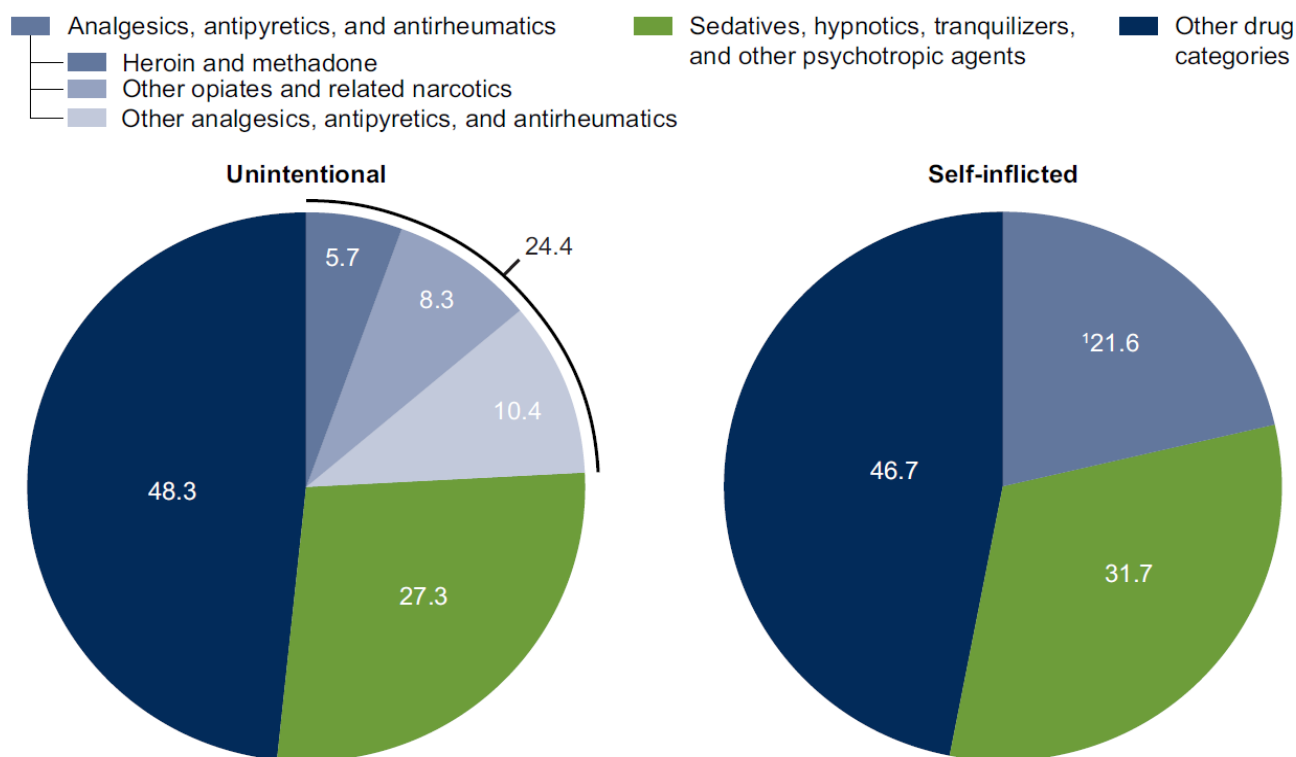
²⁵ Antirheumatics are drugs that alleviate or prevent inflammation or pain in muscles, joints, or fibrous tissue.

²⁶ Albert, M. et al. *Emergency Department Visits for Drug Poisoning: United States, 2008–2011*, NCHS Data Brief No. 196, April 2015, available at: <https://www.cdc.gov/nchs/data/databriefs/db196.htm>

²⁷ *Id.*

²⁸ Weiss, A.J., et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014*, HCUP Statistical Brief #219, January 2017, available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf> (last visited March 13, 2017).

Percentage of Emergency Department Visits for Drug Poisoning, By Intent and Drug Category:
United States, 2008–2011²⁹



SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey, 2008–2011.

Privacy Rights of Individuals Receiving Substance Abuse Treatment

Florida Protections

Section 397.501, F.S., establishes statutory rights for individuals receiving substance abuse services, including the right to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. In particular, s. 397.501(7), F.S. prohibits service providers from disclosing records containing the identity, diagnosis, and prognosis of and services provided to any individual without written consent of the individual, with certain exceptions.³⁰ The law makes service providers who violate these rights liable for damages, unless acting in good faith, reasonably, and without negligence.

Federal Protections of Personal Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.³¹ The rules address the use and disclosure of an individual's personal health information and create standards for information security. Only certain entities, "covered entities", are subject to HIPAA's provisions. Covered entities are obligated to meet HIPAA's

²⁹ Id.

³⁰ Disclosure is permitted to: health service providers in cases of medical emergency if the information is necessary to provide services to the individual; DCF for the purposes of scientific research; comply with state-mandated child abuse and neglect reporting; comply with a valid court order; report crimes that occur on program premises or against staff; federal, state or local governments for audit purposes; or third party payors providing financial assistance or reimbursement.

³¹ UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *The Privacy Rule*, available at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/> (last visited on March 13, 2017).

requirements to ensure privacy and confidentiality personal health information. These “covered entities” include:³²

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Additionally, federal law restricts the disclosure of alcohol and drug patient records maintained by federally assisted alcohol and drug abuse programs which identify a patient as an alcohol or drug abuser.³³ Disclosure of patient-identifying information is permitted in certain cases and patients may consent in writing to the disclosure of such information.³⁴

Statewide Drug Policy Advisory Council

In 1999, the Legislature created the Office of Drug Control and the Drug Policy Advisory Council³⁵ in the Executive Office of the Governor, which the Legislature replaced with the Statewide Drug Policy Advisory Council (the Council)³⁶ under the Florida Department of Health (DOH) in 2011. Among other things, the Council submits a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with recommendations.³⁷

The Council's 2016 Annual Report concluded that a key problem in combating drug overdoses Florida is that there is “no sustainable process to compile massive amounts of data and information, perform analysis and develop an evidence-based call to action” as a.³⁸ To improve data collection and surveillance, the Council recommends that DOH collaborate with other agencies, organizations, and institutions to create a comprehensive statewide strategy addressing the fentanyl and heroin overdoses in the state.³⁹

DOH Data Systems

Florida Injury Surveillance Data System

DOH's Injury Surveillance Data System is a passive data reporting mechanism that utilizes data resources from other agencies and systems, including:

- Vital records (death certificates);
- Hospital discharge data;
- Emergency department discharge data;
- Motor vehicle crash records;
- Behavioral Risk Factor Surveillance System;
- Youth Risk Behavior Surveillance System;
- Child Death Review;
- Uniform Crime Reporting System; and

³² UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *For Covered Entities and Business Associates*, available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/> (last visited on March 13, 2017).

³³ 42 CFR Part 2.

³⁴ Disclosure is allowed to comply with state-mandated child abuse and neglect reporting; to report the cause of death; to comply with a valid court order; in cases of medical emergency; to report crimes that occur on program premises or against staff; to entities having administrative control; to qualified service organizations and to outside auditors, evaluators, central registries, and researchers.

³⁵ Section 397.332, F.S., created by s. 3, ch. 99-187, Laws of Fla.

³⁶ Section 397.333, F.S., created by s. 8, ch. 2011-51, Laws of Fla.

³⁷ Section 397.333(3), F.S.

³⁸ FLORIDA DEPARTMENT OF HEALTH, *Statewide Drug Policy Advisory Council 2016 Annual Report*, (Dec. 1, 2016), p. 4, available at, <http://www.floridahealth.gov/provider-and-partner-resources/dpac/DPAC-Annual-Report-2016-FINAL.pdf> (last visited March 13, 2017).

³⁹ Id. at 14.

- Emergency medical services.⁴⁰

The Injury Surveillance Data System is used to monitor the frequency of fatal and non-fatal injuries, determine the risk factors for these injuries, evaluate the completeness, timeliness, and quality of data sources, provide information to Florida's injury prevention community for program planning and evaluation, and provide a foundation for injury prevention strategies.⁴¹ One of the injury mechanisms it receives information on is poisoning, which includes drug overdoses;⁴² however it is not currently set up to actively receive data regarding overdoses, or any other injury mechanism.⁴³

Emergency Medical Services Tracking and Reporting System (EMSTARS)

DOH maintains⁴⁴ the Emergency Medical Services Tracking and Reporting System (EMSTARS) to ensure an optimal, uniform and standard of prehospital emergency medical care statewide.⁴⁵ This system provides for the collection and analysis of incident level data from EMS agencies for benchmarking and quality improvement initiatives.⁴⁶ Participation in the EMSTARS system, and the transmission of electronic incident level data from EMS Providers⁴⁷ to DOH, is voluntary.⁴⁸ However, the complete provision of incident level data, and full participation in the EMSTARS Program, fulfills EMS Provider prehospital reporting requirements in rule 64J-1.014(1), F.A.C. The data collected by EMSTARS includes:

- All NHTSA “national” data elements for demographic data and EMS event data;
- Other selected elements identified by participants and other stakeholders;
- Demographic elements for the provider agency, its personnel, and patients;
- Incident and unit times;
- Situation and scene information;
- Patient care information including vital signs, injury assessment, trauma score, and intervention and procedural information; and
- Outcome and disposition information.⁴⁹

Additionally, EMSTARS collects minimal data elements for overdoses, especially if EMS administers an opioid antagonist.⁵⁰

The electronic patient care records submitted by licensed EMS agencies to EMSTARS are confidential and exempt pursuant to s. 401.30(4), F.S.

⁴⁰ FLORIDA DEPARTMENT OF HEALTH, *Florida Injury Surveillance Data System*, <http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/index.html> (last visited March 13, 2017).

⁴¹ Id.

⁴² FLORIDA DEPARTMENT OF HEALTH, *External Cause of Injury Intent and Mechanism Classifications and Descriptions*, (Sept. 8, 2008), available at, <http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/documents/icd-code-explanations.pdf> (last visited March 13, 2017).

⁴³ Florida Department of Health, Agency Analysis of 2017 House Bill 249, p. 6, (Jan. 17, 2017) (on file with Health Quality Subcommittee staff).

⁴⁴ In 2004, DOH signed a memorandum of understanding to participate in a national project that would standardize data collection for EMS agencies nationwide. The National Emergency Medical Services Information System is the national repository used to aggregate and analyze prehospital data from all participating states.

⁴⁵ FLORIDA DEPARTMENT OF HEALTH, *The Basic Facts: Prehospital EMS Tracking and Reporting System*, p. 1, available at, http://www.floridaemstars.com/docs/EMSTARSFactSheet_102314.pdf (last visited March 13, 2017).

⁴⁶ Id.

⁴⁷ There are 147 participating EMS agencies. FLORIDA DEPARTMENT OF HEALTH, *Florida EMS Agencies Participating in EMSTARS*, available at, <http://www.floridaemstars.com/docs/partagencies.pdf> (last visited March 13, 2017).

⁴⁸ *Supra*, note 45.

⁴⁹ Id.

⁵⁰ *Supra*, note 43.

Effect of Proposed Changes

Legislative Findings, Intent, and Goals

HB 249 makes a finding that substance abuse and drug overdose is a major health problem that affects the lives of many people, and multiple service systems that leads to profoundly disturbing consequences. The bill also makes a finding that these overdoses are a crisis and stress financial, health care, and public safety resources. Additionally, it makes a finding that a central databases that could quickly help address this problem does not currently exist.

The bill also states legislative intent to require the collaboration of local, regional, and state agencies, service systems, and program offices to achieve the goals of the Florida Comprehensive Drug Abuse Prevention and Control Act, in chapter 893, F.S., and address the needs of the public. It is unclear what goals of chapter 893, F.S., such collaboration is intended to achieve, as no goals are set forth in that chapter.⁵¹

The bill also states a legislative intent to maximize the efficiency of financial, public education, health professional, and public safety resources and to utilize funding programs for the dissemination of available federal, state, and private funds through contractual agreements with community-based organizations or units of state or local government that deliver local substance abuse services.

The goals of the act are identified as:

- Discouraging substance abuse and overdoses by quickly identifying the type of drug involved, the age of the individual involved, and the areas where drug overdoses pose a potential risk to the public, schools, workplaces, and communities; and
- Providing a central data point in each county so that data can be shared between the health care community and municipal, county, and state agencies to quickly identify needs and provide short and long term solutions while protecting and respecting the rights of individuals.

Mandatory Overdose Reporting

Currently, health care providers are not required by law to report to law enforcement when they treat or attend or are requested to treat or attend, a patient who may have overdosed on a controlled substance. The bill creates s. 893.22, F.S., which requires mandatory reporting of controlled substances overdoses. The bill defines “overdose” as a condition which includes, but is not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death from the consumption or use of a controlled substance that requires medical attention or a condition which creates a clinical suspicion of a drug overdose such as respiratory depression, unconsciousness, or an altered mental state which is not explained by another condition.

The mandatory reporting requirement applies to physicians, nurses, paramedics, emergency medical technicians, health care workers, and employees of these professionals. It also applies to any employee of a hospital, sanatorium or other institution or provider. If any of these specified individuals knowingly attends, treats, or is requested to attend or treat a person who has an overdose of a controlled substance as listed in s. 893.03, F.S., they must make a report to law enforcement within 24 hours. The report must contain:

- The date of the overdose;
- The approximate age of the patient,
- A list of the suspected kind and quantity of the controlled substance; and

⁵¹ Chapter 893, F.S., sets out the schedules of controlled substances, establishes laws controlling the manufacture, distribution, preparation, dispensing, or administration of such substances, and sets out criminal penalties for violations of those laws.

- The address of where the patient was picked up, where the overdose took place, or where the patient resides.

Reporting this information may be sufficient to trigger patient privacy concerns.

The bill does not limit the number of people who would be required to report on a single overdose; as a result, is possible, given the breadth of the individuals required to report, that there will be overlapping reports covering the same overdose. Because each individual who treats, attends, or is asked to treat or attend such a patient, must file a report, and a report must be filed each time the reporting individual treats, attends, or is asked to treat or attend such a patient, any incident is likely to result in redundant reports.

Anyone who files a report in good faith is not subject to civil or criminal liability for making the report.

Use of Report

The bill requires the report to be filed with the county sheriff or chief law enforcement officer of the county within 24 hours. However, the sheriff or chief law enforcement office may designate or partner with another agency, such as the medical examiner, to receive, store, and manage these reports. The reports must be maintained for five years. Regardless of who maintains the reports, law enforcement officers may access the records of these reports without obtaining a subpoena, search warrant, or other court order.

Additionally, the law enforcement officer who receives these reports then shares the general data, other than any data about criminal charges, with health care professionals and the county health department. Each county health department must then make semi-annual reports to the Council that summarizes the data it receives from law enforcement. The Council may use the reports to maximize the utilization of funding programs for substance abuse treatment services. It is unclear how the Council will use the data to maximize the use of funding, since it is merely advisory.

Penalties for Failure to Report

A mandatory reporter who fails to make a report is subject to criminal penalties. A person who fails by omission to make a required report within 24 hours of the treatment of a patient suffering from an overdose is guilty of a second-degree misdemeanor, which can result in a fine of up to \$500 and a sentence of up to 60 days. A person who willfully fails to make a required report within 24 hours of the treatment of a patient suffering from an overdose is guilty of a second-degree misdemeanor, which can result in a fine of up to \$500 and a sentence of up to 60 days.

B. SECTION DIRECTORY:

Section 1: Provides legislative findings and intent

Section 2: Creates s. 893.22, F.S., relating to mandatory reporting of controlled substance overdoses.

Section 3: Provides an effective date of October 1, 2017

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The reporting methods could require acquisition of new or additional software to collect and aggregate data.⁵² In addition, county health departments may experience a recurring increase in workload associated with additional data they must collect from law enforcement and the semi-annual reports they must make to the Council.⁵³ The impact is indeterminate at this time; therefore, DOH cannot calculate the full fiscal impact, but notes that it could be significant.⁵⁴

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Public EMS providers could incur additional costs related to enhanced reporting requirements.⁵⁵

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Mandatory reporters will have to take time away from other work to comply with the reporting requirements in the bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

⁵² *Supra*, note 43.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*